RULES
OF
THE TENNESSEE DEPARTMENT OF HEALTH
BOARD FOR LICENSING HEALTH CARE FACILITIES

CHAPTER 1200-8-27
STANDARDS FOR HOMECARE ORGANIZATIONS PROVIDING HOSPICE SERVICES

TABLE OF CONTENTS

1200-8-27-.01 DEFINITIONS.

(1) Administrator. A person who:

(a) Is a licensed physician with at least one (1) year supervisory or administrative experience in home health care, hospice care or related health programs; or

(b) Is a registered nurse with at least one (1) year supervisory or administrative experience in home health care, hospice care or related health programs; or

(c) Has training and experience in health service administration and at least one (1) year of supervisory or administrative experience in home health care, hospice care or related health programs.

(2) Adult. An individual who has capacity and is at least 18 years of age.

(3) Advance Directive. An individual instruction or a written statement relating to the subsequent provision of health care for the individual, including, but not limited to, a living will or a durable power of attorney for health care.

(4) Agent. An individual designated in an advance directive for health care to make a health care decision for the individual granting the power.

(5) Agency. A Home Care Organization providing hospice services.

(6) Bereavement Counselor. An individual who has at least a bachelor's degree in social work, counseling, psychology, pastoral care or specialized training or experience in bereavement theory and counseling.

(7) Board. The Tennessee Board for Licensing Health Care Facilities.

(8) Capacity. An individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision. These regulations do not affect the right of a patient to make health care decisions while having the capacity to do so. A patient shall be presumed to have capacity to make a health care decision, to give or revoke an advance directive, and to designate or disqualify a surrogate. Any person who challenges the capacity of a patient shall have the burden of proving lack of capacity.

(Rule 1200-8-27-.01, continued)

(9) Cardiopulmonary Resuscitation (CPR). The administering of any means or device to support cardiopulmonary functions in a patient, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual or mechanical ventilations or respirations, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a patient where cardiac or respiratory arrest has occurred or is believed to be imminent.

(10) Certified Master Social Worker. A person currently certified as such by the Tennessee Board of Social Worker Certification and Licensure.

(11) Clinical Note. A written and dated notation containing a patient assessment, responses to medications, treatments, services, any changes in condition and signed by a health team member who made contact with the patient.

(12) Commissioner. The Commissioner of the Tennessee Department of Health or his or her authorized representative.

(13) Competent. A patient who has capacity.

(14) Core Services. Services consisting of nursing, medical social services, physician services and counseling services.

(15) Corrective Action Plan/Report. A report filed with the department by the facility after reporting an unusual event. The report must consist of the following:

(a) the action(s) implemented to prevent the reoccurrence of the unusual event,

(b) the time frames for the action(s) to be implemented,

(c) the person(s) designated to implement and monitor the action(s), and

(d) the strategies for the measurements of effectiveness to be established.

(16) Department. The Tennessee Department of Health.

(17) Designated Physician. A physician designated by an individual or the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes such responsibility.

(18) Do Not Resuscitate (DNR) Order. An order entered by the patient's treating physician in the patient's medical record which states that in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted. The order may contain limiting language to allow only certain types of cardiopulmonary resuscitation to the exclusion of other types of cardiopulmonary resuscitation.

(19) Emancipated Minor. Any minor who is or has been married or has by court order or otherwise been freed from the care, custody and control of the minor's parents.

(20) Emergency Responder. A paid or volunteer firefighter, law enforcement officer, or other public safety official or volunteer acting within the scope of his or her proper function under law or rendering emergency care at the scene of an emergency.

(Rule 1200-8-27-.01, continued)

(21) Guardian. A judicially appointed guardian or conservator having authority to make a health care decision for an individual.

(22) Hazardous Waste. Materials whose handling, use, storage and disposal are governed by local, state or federal regulations.

(23) Health Care. Any care, treatment, service or procedure to maintain, diagnose, treat, or otherwise affect an individual's physical or mental condition, and includes medical care as defined in T.C.A. § 32-11-103(5).

(24) Health Care Decision. Consent, refusal of consent or withdrawal of consent to health care.

(25) Health Care Decision-maker. In the case of a patient who lacks capacity, the patient's health care decision-maker is one of the following: the patient's health care agent as specified in an advance directive, the patient's court-appointed guardian or conservator with health care decision-making authority, the patient's surrogate as determined pursuant to Rule 1200-8-27-.13 or T.C.A. §33-3-220, the designated physician pursuant to these Rules or in the case of a minor child, the person having custody or legal guardianship.

(26) Health Care Institution. A health care institution as defined in T.C.A. § 68-11-1602.

(27) Health Care Provider. A person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business or practice of a profession.

(28) Home Care Organization. As defined by T.C.A. § 68-11-201, a "home care organization" provides home health services, home medical equipment services or hospice services to patients on an outpatient basis in either their regular or temporary place of residence.

(29) Home Health Aide/Hospice Aide. A person who has completed a total of seventy-five (75) hours of training which included sixteen (16) hours of clinical training prior to or during the first three (3) months of employment and who is qualified to provide basic services, including simple procedures as an extension of therapy services, personal care regarding nutritional needs, ambulation and exercise, and household services essential to health care at home.

(30) Homemaker Service. A non-skilled service in the home to maintain independent living which does not require a physician's order. An agency does not have to be licensed as a home care organization to provide such services.

(31) Hospice Services. As defined by T.C.A. § 68-11-201, "hospice services" means a coordinated program of care, under the direction of an identifiable hospice administrator, providing palliative and supportive medical and other services to hospice patients and their families in the patient's regular or temporary place of residence. Hospice services shall be provided twenty-four (24) hours a day, seven (7) days a week.

(32) Incompetent. A patient who has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.

(33) Individual instruction. An individual's direction concerning a health care decision for the individual.

(34) Infectious Waste. Solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host could result in an infectious disease.

(35) Licensed Clinical Social Worker. A person currently licensed as such by the Tennessee Board of Social Workers.

(Rule 1200-8-27-.01, continued)

(36) Licensed Practical Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(37) Licensee. The person or entity to whom the license is issued. The licensee is held responsible for compliance with all rules and regulations.

(38) Life Threatening or Serious Injury. Injury requiring the patient to undergo significant additional diagnostic or treatment measures.

(39) Medical Record. Medical histories, records, reports, clinical notes, summaries, diagnoses, prognoses, records of treatment and medication ordered and given, entries and other written electronic or graphic data prepared, kept, made or maintained in an agency that pertains to confinement or services rendered to patients.

(40) Medical Social Services. Medical social services must be provided by a qualified social worker under the direction of a physician, in accordance with the plan of care.

(41) Medically Inappropriate Treatment. Resuscitation efforts that cannot be expected either to restore cardiac or respiratory function to the patient or other medical or surgical treatments to achieve the expressed goals of the informed patient. In the case of the incompetent patient, the patient's representative expresses the goals of the patient.

(42) Occupational Therapist. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(43) Occupational Therapy Assistant. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(44) Palliative. The reduction or abatement of pain or troubling symptoms, by appropriate coordination of all elements of the hospice care team, to achieve needed relief of distress.

(45) Patient. Hospice patient means only a person who has been diagnosed as terminally ill; been certified by a physician in writing to have an anticipated life expectancy of six (6) months or less; has voluntarily through self or a surrogate requested admission to a hospice; and been accepted by a licensed hospice.

(46) Patient Abuse. Patient neglect, intentional infliction of pain, injury, or mental anguish. Patient abuse includes the deprivation of services by a caretaker which are necessary to maintain the health and welfare of a patient or resident; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of such living will shall not be deemed "patient abuse" for purposes of these rules.

(47) Person. An individual, corporation, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(48) Personally Informing. A communication by any effective means from the patient directly to a health care provider.

(49) Physical Therapist. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(50) Physical Therapy Assistant. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(Rule 1200-8-27-.01, continued)

(51) Physician. An individual authorized to practice medicine or osteopathy under Tennessee Code Annotated, Title 63, Chapters 6 or 9.

(52) Power of Attorney for Health Care. The designation of an agent to make health care decisions for the individual granting the power under T.C.A. Title 34, Chapter 6, Part 2.

(53) Qualified Emergency Medical Service Personnel. Includes, but shall not be limited to, emergency medical technicians, paramedics, or other emergency services personnel, providers, or entities acting within the usual course of their professions, and other emergency responders.

(54) Reasonably Available. Readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health care needs. Such availability shall include, but not be limited to, availability by telephone.

(55) Registered Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(56) Respiratory Technician. A person currently licensed as such by the Tennessee Board of Respiratory Care.

(57) Respiratory Therapist. A person currently licensed as such by the Tennessee Board of Respiratory Care.

(58) Respite Care. A short-term period of inpatient care provided to the patient only when necessary to relieve the family members or other persons caring for the patient.

(59) Shall or Must. Compliance is mandatory.

(60) Social Work Assistant. A person who has a baccalaureate degree in social work, psychology, sociology or other field related to social work, and has at least one (1) year of social work experience in a health care setting. Social work related fields include bachelor/masters degrees in psychology, sociology, human services (behavioral sciences, not human resources), masters degree in counseling fields (psychological guidance and guidance counseling) and degrees in gerontology.

(61) Speech Language Pathologist. A person currently licensed as such by The Tennessee Board of Communication Disorders and Sciences.

(62) Spiritual Counselor. A person who has met the requirements of a religious organization to serve the constituency of that religious organization.

(63) State. A state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(64) Student. A person currently enrolled in a course of study that is approved by the appropriate licensing board or equivalent body.

(65) Supervising Health Care Provider. The designated physician or, if there is no designated physician or the designated physician is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care.

(66) Supervision. Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity with initial direction and periodic inspection of the actual act of accomplishing the function or activity. Periodic supervision must be provided if the person is not a licensed or certified assistant, unless otherwise provided in accordance with these rules.

(Rule 1200-8-27-.01, continued)

(67) Surrogate. An individual, other than a patient's agent or guardian, authorized to make a health care decision for the patient.

(68) Terminally ill. An individual with a medical prognosis that his or her life expectancy is six (6) months or less if the illness runs its normal course.

(69) Treating Health Care Provider. A health care provider who at the time is directly or indirectly involved in providing health care to the patient.

(70) Universal Do Not Resuscitate Order. A written order that applies regardless of the treatment setting and that is signed by the patient's physician which states that in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted. The Physician Order for Scope of Treatment (POST) form promulgated by the Board for Licensing Health Care Facilities as a mandatory form shall serve as the Universal DNR according to these rules.

(71) Unusual Event. The abuse of a patient or an unexpected occurrence or accident that results in death, life threatening or serious injury to a patient that is not related to a natural course of the patient's illness or underlying condition.

(72) Unusual Event Report. A report form designated by the department to be used for reporting an unusual event.

(73) Volunteer. An individual who agrees to provide services to a hospice care patient and/or family member(s), without monetary compensation, in either direct patient care or an administrative role and supervised by an appropriate hospice care employee.

Authority: *T.C.A. §§4-5-202, 4-5-204, 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, and 68-11-1802.* ***Administrative History:*** *Original rule filed April 17, 2000; effective July 1, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003. Amendments filed December 2, 2005; effective February 15, 2006. Amendment filed February 7, 2007; effective April 23, 2007.*

1200-8-27-.02 LICENSING PROCEDURES.

(1) No person, partnership, association, corporation or any state, county or local government unit, or any division, department, board or agency thereof shall establish, conduct, operate or maintain in the State of Tennessee any Home Care Organization providing Hospice Services without having a license. A license shall be issued to the person or persons named and for the premises listed in the application for licensure and for the geographic area specified by the certificate of need or at the time of the original licensing. The name of the agency shall not be changed without first notifying the Department in writing. Licenses are not transferable or assignable and shall expire annually on June 30th. The license shall be conspicuously posted in the agency.

(2) In order to make application for a license:

(a) The applicant shall submit an application on a form prepared by the Department.

(b) Each applicant for a license shall pay an annual license fee in the amount of one thousand eighty dollars ($1,080.00). The fee must be submitted with the application and is not refundable.

(c) The issuance of an application form is in no way a guarantee that the completed application will be accepted or that a license will be issued by the Department. Patients shall not be admitted to the agency until a license has been issued. Applicants shall not hold themselves out to the public as being an agency until the license has been issued. A license shall not be issued until the agency is in substantial compliance with these rules, including submission of all information

(Rule 1200-8-27-.02, continued)

required by T.C.A. §68-11-206(1) or as later amended, and all information required by the Commissioner.

(d) The applicant must prove the ability to meet the financial needs of the agency.

(e) The applicant shall not use subterfuge or other evasive means to obtain a license, such as filing for a license through a second party when an individual has been denied a license or has had a license disciplined or has attempted to avoid inspection and review process.

(3) A proposed change of ownership, including a change in a controlling interest, must be reported to the Department a minimum of thirty (30) days prior to the change. A new application and fee must be received by the Department before the license may be issued.

(a) For the purposes of licensing, the licensee of an agency has the ultimate responsibility for the operation of the agency, including the final authority to make or control operational decisions and legal responsibility for the business management. A change of ownership occurs whenever this ultimate legal authority for the responsibility of the agency's operation is transferred.

(b) A change of ownership occurs whenever there is a change in the legal structure by which the agency is owned and operated.

(c) Transactions constituting a change of ownership include, but are not limited to the following:

1. Transfer of the agency's legal title;

2. Lease of the agency's operations;

3. Dissolution of any partnership that owns, or owns a controlling interest in, the agency;

4. One partnership is replaced by another through the removal, addition or substitution of a partner;

5. Removal of the general partner or general partners, if the agency is owned by a limited partnership;

6. Merger of an agency owner (a corporation) into another corporation where, after the merger, the owner's shares of capital stock are canceled;

7. The consolidation of a corporate agency owner with one or more corporations; or

8. Transfers between levels of government.

(d) Transactions which do not constitute a change of ownership include, but are not limited to, the following:

1. Changes in the membership of a corporate board of directors or board of trustees;

2. Two (2) or more corporations merge and the originally-licensed corporation survives;

3. Changes in the membership of a non-profit corporation;

4. Transfers between departments of the same level of government; or

5. Corporate stock transfers or sales, even when a controlling interest.

(Rule 1200-8-27-.02, continued)

(e) Management agreements are generally not changes of ownership if the owner continues to retain ultimate authority for the operation of the agency. However, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.

(f) Sale/lease-back agreements shall not be treated as changes in ownership if the lease involves the agency's entire real and personal property and if the identity of the lessee, who shall continue the operation, retains the exact same legal form as the former owner.

(4) To be eligible for a license or renewal of a license, each agency shall be periodically inspected for compliance with these regulations. If deficiencies are identified, an acceptable plan of correction shall be established and submitted to the Department.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed April 17, 2000; effective July 1, 2000. Amendment filed November 19, 2003; effective February 2, 2004. Amendment filed January 19, 2007; effective April 4, 2007.*

1200-8-27-.03 DISCIPLINARY PROCEDURES.

(1) The Board may suspend or revoke a license for:

(a) Violation of federal or state statutes;

(b) Violation of the rules as set forth in this chapter;

(c) Permitting, aiding or abetting the commission of any illegal act in the agency;

(d) Conduct or practice found by the Board to be detrimental to the health, safety, or welfare of the patients of the agency; or

(e) Failure to renew the license.

(2) The Board may consider all factors which it deems relevant, including but not limited to the following when determining sanctions:

(a) The degree of sanctions necessary to ensure immediate and continued compliance;

(b) The character and degree of impact of the violation on the health, safety and welfare of the patient in the agency;

(c) The conduct of the agency in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and

(d) Any prior violations by the agency of statutes, rules or orders of the Board.

(3) When an agency is found by the Department to have committed a violation of this chapter, the Department will issue to the agency a statement of deficiencies. Within ten (10) days of receipt of the statement of deficiencies the agency must return a plan of correction indicating the following:

(a) How the deficiency will be corrected;

(b) The date upon which each deficiency will be corrected;

(c) What measures or systemic changes will be put in place to ensure that the deficient practice does not recur; and

(Rule 1200-8-27-.03, continued)

(d) How the corrective action will be monitored to ensure that the deficient practice does not recur.

(4) Either failure to submit a plan of correction in a timely manner or a finding by the Department that the plan of correction is unacceptable shall subject the agency's license to possible disciplinary action.

(5) Any licensee or applicant for a license, aggrieved by a decision or action of the Department or Board, pursuant to this chapter, may request a hearing before the Board. The proceedings and judicial review of the board's decision shall be in accordance with the Uniform Administrative Procedures Act, T.C.A. §§ 4-5-101, et seq.

(6) Reconsideration and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

Authority: *T.C.A. §§4-5-202, 4-5-204, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-202, 68-11-204, and 68-11-206 through 68-11-209.* ***Administrative History:*** *Original rule filed April 25, 1996; effective July 9, 1996. Repeal and new rule filed April 17, 2000; effective July 1, 2000. Amendment filed March 1, 2007; effective May 15, 2007.*

1200-8-27-.04 ADMINISTRATION.

(1) Governing Body. A hospice service program must have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice program's total operation. The governing body must designate an individual who is responsible for the day to day management of the hospice program. The governing body must also ensure that all hospice services provided are consistent with accepted standards of practice.

(2) The hospice agency must organize, manage and administer its hospice services to attain and maintain the highest practicable functional capacity for each patient in a manner consistent with acceptable standards of practice.

(3) The hospice agency shall ensure a framework for addressing issues related to care at the end of life.

(4) The hospice agency shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

(5) Nursing services, physician services, drugs and biologicals shall routinely be available on a 24-hour basis.

(6) All other hospice services shall be available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness or conditions directly attributable to the terminal diagnosis.

(7) Professional Management. A hospice service program may contract for another individual or entity to furnish services, other than core services, to the hospice program's patients. If services are provided under agreement or contract, the hospice program must meet the following standards:

(a) Continuity of care. The hospice program assures the continuity of patient/family care.

(b) Written agreement. The hospice service program has a legally binding written agreement for the provision of hospice services. The agreement includes at least the following:

1. Identification of the services to be provided.

(Rule 1200-8-27-.04, continued)

2. A stipulation that services may be provided only with the express authorization of the hospice program.

3. The manner in which the contracted services are coordinated, supervised and evaluated by the hospice program.

4. The delineation of the role(s) of the hospice program and the contractor in the admission process, patient/family assessment and the interdisciplinary group care conferences.

5. Requirements for documenting that services are furnished in accordance with the agreement.

6. The qualifications of the personnel providing the services.

(c) Professional management responsibility. The hospice program retains professional management responsibility for those contracted services and ensures that they are furnished in a safe and effective manner by persons meeting the qualifications of this chapter, and in accordance with the patient's plan of care and the other requirements of this chapter.

(d) Financial responsibility. The hospice program retains responsibility for payment for services.

(8) The organizational structure, hospice services provided, administrative control and lines of authority for the delegation of responsibility down to the patient care level shall be clearly set forth in writing and shall be readily identifiable. Administrative and supervisory functions shall not be delegated to another agency. All hospice services not provided directly by the licensed agency shall be monitored and controlled by that agency. Supervisory functions shall not be delegated to another home care organization. When a home care organization provides hospice services at more than one location, it must comply with the following:

(a) Each location must provide the same full range of services that is required of the hospice issued license (parent);

(b) Each location must be responsible to the same governing body and central administration that governs the hospice issued license (parent), and the governing body and central administration must be able to adequately manage each location;

(c) Clinical records must be maintained for all patients, regardless of where services are provided; and

(d) All hospice patients' clinical records requested by the surveyor must be available at the hospice site issued the license (parent).

If a home care organization providing hospice services at an additional location is unable to comply with these requirements, it is operating as a separate entity, and must be separately licensed.

(9) Hospice services may be provided in an area designated by a hospital for exclusive use by a home care organization certified as a hospice provider to provide care at the hospice inpatient or respite level of care in accordance with the hospice's Medicare certification. Admission to the hospital is not required in order for a patient to receive such hospice services, regardless of the patient's length of stay. The designation by a hospital of a portion of its facility for exclusive use by a home care organization to provide hospice services to its patients shall not:

(a) alter the license to bed complement of such hospital, or

(Rule 1200-8-27-.04, continued)

(b) result in the establishment of a residential hospice.

(10) The administrator shall organize and direct the organization's ongoing functions; maintain ongoing liaison among the governing body, the professional personnel and the staff; employ qualified personnel and ensure adequate staff education and evaluation for all personnel involved in direct patient care; ensure the accuracy of public information materials and activities; and implement an effective budgeting and accounting system. A person with sufficient experience and training shall be authorized in writing to assume temporary duty during the administrator's short-term absence.

(11) An agency shall have a duly qualified administrator accessible during normal operating hours. Any change of administrators shall be reported to the Department within fifteen (15) days.

(12) An administrator shall serve no more than one (1) licensed home care organization unless that home care organization provides other categories of home care organization services under the same ownership and at the same location.

(13) The agency shall maintain an office with a working telephone and be staffed during normal business hours.

(14) When licensure is applicable for a particular job, a copy of the current license or the number and renewal number of the current license must be maintained in the personnel file. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee. Proof of adequate medical screenings to exclude communicable disease shall be maintained in the file of each employee.

(15) Personnel practices shall be supported by written personnel policies. Personnel records shall include at a minimum: job descriptions, verification of references and credentials, and performance evaluations. Personnel records must be kept current.

(16) An ongoing educational program shall be planned and conducted for the development and improvement of skills of all the organization's personnel engaged in delivery of hospice services. Each employee shall receive appropriate orientation to the organization, its policies, the employee's position, and the employee's duties. Records shall be maintained which indicate the subject of and attendance at such staff development programs.

(17) If personnel under hourly or per visit contracts are utilized by the agency, there shall be a written contract between such personnel and the organization clearly designating:

(a) That patients are accepted for care only by the agency;

(b) Which hospice services are to be provided;

(c) That it is necessary to conform to all applicable organization policies including personnel qualifications;

(d) The responsibility for participating in developing plans of care;

(e) The manner in which hospice services will be controlled, coordinated and evaluated by the agency;

(f) The procedures for submitting clinical and progress notes, scheduling visits and periodic patient evaluations; and

(g) The procedures for determining charges and reimbursement.

(Rule 1200-8-27-.04, continued)

(18) Whenever the rules of this chapter require that a licensee develop a written policy, plan, procedure, technique or system concerning a subject, the licensee shall develop the required policy, maintain it and adhere to its provisions. An agency which violates a required policy also violates the rule establishing the requirement.

(19) Policies and procedures shall be consistent with professionally recognized standards of practice.

(20) All agencies shall adopt appropriate policies regarding the testing of patients and staff for human immunodeficiency virus (HIV) and any other identified causative agent of acquired immune deficiency syndrome.

(21) Each agency utilizing students shall establish policies and procedures for their supervision.

(22) No agency shall retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the Board, the Department, the Department of Human Services Adult Protective Services or the Comptroller of the State Treasury. An agency shall neither retaliate nor discriminate because of information lawfully provided to these authorities, because of a person's cooperation with them, or because a person is subpoenaed to testify at a hearing involving one of these authorities.

(23) All health care facilities licensed pursuant to T.C.A. §§ 68-11-201, et seq. shall post the following in the main public entrance:

(a) Contact information including statewide toll-free number of the division of adult protective services, and the number for the local district attorney's office;

(b) A statement that a person of advanced age who may be the victim of abuse, neglect, or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect and exploitation; and

(c) A statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline, with that number printed in boldface type, for immediate assistance and posted on a sign no smaller than eight and one-half inches (8½") in width and eleven inches (11") in height.

Postings of (a) and (b) shall be on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-222 and 71-6-121.* ***Administrative History:*** *Original filed April 25, 1996; effective July 9, 1996. Repeal and new rule filed April 17, 2000; effective July 1, 2000. Amendment filed June 18, 2002; effective September 1, 2002. Amendment filed April 20, 2006; effective July 4, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed July 18, 2007; effective October 1, 2007.*

1200-8-27-.05 ADMISSIONS, DISCHARGES AND TRANSFERS.

(1) The hospice service program shall have a policy to admit only patients who meet the following criteria:

(a) Has been diagnosed as terminally ill;

(b) Has been certified by a physician, in writing, to have an anticipated life expectancy of six (6) months or less;

(c) Has personally or through a representative voluntarily requested admission to, and been accepted by, a licensed hospice service organization; and

(Rule 1200-8-27-.05, continued)

(d) Has personally or through a representative, in writing, given informed consent to receive hospice care.

(2) Patients shall be accepted to receive hospice services on the basis of a reasonable expectation that the patient's medical, nursing and psychosocial needs can be met adequately by the organization in the patient's regular or temporary place of residence.

(3) Care shall follow a written plan of care established and reviewed by the attending physician, the medical director or physician designee and the interdisciplinary group prior to providing care. Care shall continue under the supervision of the attending physician.

(4) The agency staff shall determine if the patient's needs can be met by the organization's services and capabilities.

(5) Every person admitted for care or treatment to any agency covered by these rules shall be under the supervision of a physician as defined in this chapter who holds a license in good standing. The name of the patient's attending physician shall be recorded in the patient's medical record.

(6) The agency staff shall obtain the patient's written consent for hospice services.

(7) The signed consent form shall be included with the patient's individual clinical record.

(8) A diagnosis must be entered in the admission records of the agency for every person admitted for care or treatment.

(9) No medication or treatment shall be provided to any patient of an agency except on the order of a physician or dentist lawfully authorized to give such an order.

(10) A medical record shall be developed and maintained for each patient admitted.

(11) No patient shall be involuntarily discharged without a written order from the attending physician or the medical director stating the patient does not meet hospice criteria, or through other legal processes, and timely notification of next of kin and/or the authorized representative.

(12) When a patient is discharged, a summary of the significant findings and events of the patient's care, the patient's condition on discharge and the recommendation and arrangement for future care, if any, is required.

(13) The agency shall ensure that no person on the grounds of race, color, national origin or handicap, will be excluded from participation in, be denied benefits of, or otherwise subjected to discrimination in the provision of any care or service of the agency. The agency shall protect the civil rights of patients under the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, and 68-11-209.* ***Administrative History:*** *Original rule filed April 17, 2000; effective July 1, 2000.*

1200-8-27-.06 BASIC AGENCY FUNCTIONS.

(1) An organization providing hospice services must ensure that substantially all core services are routinely provided directly by hospice employees. A hospice service program may use contracted staff if necessary to supplement hospice service program employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the organization providing hospice services must maintain professional, financial and administrative

(Rule 1200-8-27-.06, continued)

responsibility for the services and must assure that the qualifications of staff and services provided meet the requirements specified in this rule.

(a) Nursing services. The hospice service program must provide nursing care and services by or under the supervision of a registered nurse (R.N.) at all times.

1. Nursing services must be directed and staffed to assure the nursing needs of patients are met.

2. Patient care responsibilities of nursing personnel must be specified.

3. Hospice services must be provided in accordance with recognized standards of practice.

4. A registered nurse may make the actual determination and pronouncement of death under the following circumstances:

(i) The deceased was receiving the services of a licensed home care organization providing Medicare-certified hospice services;

(ii) Death was anticipated, and the attending physician and/or the hospice medical director has agreed in writing to sign the death certificate. Such agreement must be present with the deceased at the place of death;

(iii) The nurse is licensed by the state; and,

(iv) The nurse is employed by the home care organization providing hospice services to the deceased.

(b) Medical Social Services. Medical Social Services must be provided by a qualified social worker under the direction of a physician.

(c) Physician Services. In addition to palliation and management of terminal illness and related conditions, physician employees of the hospice service program, including the physician member(s) of the interdisciplinary group, must also meet the general medical needs of the patients to the extent these needs are not met by the attending physician.

(d) Counseling Services. Counseling services must be made available to both the patient and the family. Counseling includes bereavement counseling, provided both prior to and after the patient's death, as well as dietary, therapeutic, spiritual and any other counseling services identified in the Plan of Care for the patient and family.

1. Bereavement counseling. There must be an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care for these services should reflect family needs, services to be provided and the frequency of services.

2. Dietary counseling. Dietary counseling, when required, must be provided by a qualified individual.

3. Spiritual counseling. Spiritual counseling must include notice as to the availability of clergy.

4. Additional counseling. Counseling may be provided by other members of the interdisciplinary group as well as by other qualified professionals as determined by the hospice program.

(Rule 1200-8-27-.06, continued)

(2) Plan of Care. A written plan of care must be established and maintained for each patient admitted to a hospice program and the care provided must be in accordance with the plan.

(a) Establishment of plan. The plan must be established by the attending physician, the medical director or the physician's designee and the interdisciplinary group prior to providing care.

(b) Review of plan. The plan must be reviewed and updated as the patient's condition changes, but at intervals of no more than fourteen (14) days, by the attending physician, the medical director or the physician's designee and the interdisciplinary group. These reviews must be documented.

(c) Content of plan. The plan must include an assessment of the individual's needs and identification of the hospice services required, including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

(3) Interdisciplinary Group. The organization providing hospice services must designate an interdisciplinary group(s) composed of individuals who provide or supervise the care and services offered by the hospice program:

(a) Composition of Group. The hospice service program must have an interdisciplinary group or groups that include at least the following individuals who are employees of the hospice service program:

1. A doctor of medicine or osteopathy;

2. A registered nurse;

3. A social worker; and

4. A pastoral or other counselor.

(b) Role of Group. The interdisciplinary group is responsible for:

1. Participation in the establishment of the plan of care;

2. Provision or supervision of hospice care and services;

3. Periodic review and updating of the plan of care for each individual receiving hospice care; and

4. Establishment of policies governing the day-to-day provision of hospice care and services.

(c) If a hospice service program has more than one interdisciplinary group, it must designate in advance the group it chooses to execute the functions described in part (b) of this paragraph.

(4) Coordinator. The hospice service program must designate a registered nurse to coordinate the implementation of the plan of care of each patient.

(5) Volunteers. The hospice service program may use volunteers, in defined roles, under the supervision of a designated hospice program employee.

(Rule 1200-8-27-.06, continued)

(a) Training. The hospice program must provide appropriate orientation and training that is consistent with acceptable standards of hospice practice.

(b) Role. Volunteers may be used in administrative or direct patient care roles.

1. Recruiting and retaining. The hospice must document active and ongoing efforts to recruit and train volunteers.

2. Availability of clergy. The hospice service program must make reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community to patients who request such visits and must advise patients of this opportunity.

(6) Continuation of Care. An organization providing hospice services must assist in coordinating continued care should the patient be transferred or discharged from the hospice program or the organization.

(7) Short Term Inpatient Care. Short term inpatient care is available for pain control, symptom management and respite services, and if not provided directly, must be provided under a legally binding written agreement that meets the requirements of subparagraph (b) of this paragraph in a licensed nursing home, hospital, or residential hospice which meets the following minimum requirements:

(a) Whether provided directly or indirectly, the facility that provides short term inpatient care must provide twenty-four (24) hour nursing services which are sufficient to meet total nursing needs in accordance with the patient's plan of care. Each hospice patient must receive treatments, medications, and diet as prescribed, and must be kept comfortable, clean, well-groomed and protected from accident, injury and infection. Each shift must include a registered nurse (R.N.) who provides direct patient care.

(b) The facility must be designed and equipped for the comfort and privacy of each hospice patient and family member(s) by providing physical space for private patient/family visiting, accommodations for family members to remain with the patient throughout the night, accommodations for family privacy following a patient's death and decor which is home-like in design and function.

(c) The hospice must furnish to the inpatient provider a copy of the patient's plan of care and specify the inpatient services to be furnished.

(d) The inpatient provider must have established policies consistent with those of the hospice and agree to abide by the patient care protocols established by the hospice for its patients.

(e) The medical record must include a record of all inpatient services and events. A copy of the discharge summary must be provided to the hospice and, if requested, a copy of the medical record is to be provided to the hospice.

(f) The written agreement must designate the party responsible for the implementation of the provisions of the agreement.

(g) The hospice shall retain responsibility for appropriate hospice care training of the personnel who provide the care under the agreement.

(8) Drugs and treatments shall be administered by appropriately licensed agency personnel, acting within the scope of their licenses. Oral orders for drugs and treatments shall be given to appropriately

(Rule 1200-8-27-.06, continued)

licensed personnel acting within the scope of their licenses, immediately recorded, signed and dated, and countersigned and dated by the physician.

(9) Performance Improvement Program. Each agency must conduct an ongoing, comprehensive, integrated, self-assessment of the quality and appropriateness of past and present care provided, including inpatient care and contract services. The written performance improvement plan findings are to be used by the hospice to determine the appropriateness and effectiveness of the care provided and to ascertain that professional policies are followed in providing these services. The objectives of those responsible for the performance improvement program are as follows:

(a) To assist the agency in using its personnel and facilities to meet individual and community needs;

(b) To identify and correct problems and/or deficiencies which undermine quality of care and lead to waste of agency and personnel resources;

(c) To help the agency make critical judgments regarding the quality and quantity of its services through self-examination;

(d) To provide opportunities to evaluate the effectiveness of agency policies and when necessary make recommendations to the administration as to controls or changes needed to assure high standards of patient care;

(e) To provide data needed to satisfy state licensure and federal certification requirements; and

(f) To establish criteria to measure the effectiveness and efficiency of the hospice services provided to patients.

(10) Infection Control.

(a) There must be an active performance improvement program for developing guidelines, policies, procedures and techniques for the prevention, control and investigation of infections and communicable diseases.

(b) Formal provisions must be developed to educate and orient all appropriate personnel and/or family members in the practice of aseptic techniques such as handwashing and scrubbing practices, proper hygiene, use of personal protective equipment, dressing care techniques, disinfecting and sterilizing techniques, and the handling and storage of patient care equipment and supplies.

(c) Continuing education shall be provided for all agency patient care providers on the cause, effect, transmission, prevention and elimination of infections, as evidenced by the ability to verbalize/or demonstrate an understanding of basic techniques.

(d) The agency shall develop policies and procedures for testing a patient's blood for the presence of the hepatitis B virus and the HIV (AIDS) virus in the event that an employee of the agency, a student studying at the agency or other health care provider rendering services at the agency is exposed to a patient's blood or other body fluid. The testing shall be performed at no charge to the patient, and the test results shall be confidential.

(e) The agency and its employees shall adopt and utilize standard precautions (per CDC) for preventing transmission of infections, HIV and communicable diseases.

(Rule 1200-8-27-.06, continued)

(f) Precautions shall be taken to prevent the contamination of sterile and clean supplies by soiled supplies. Sterile supplies shall be packaged and stored in a manner that protects the sterility of the contents.

(11) Home Health Aide/Hospice Aide Services. Home Health Aide Services must be available and adequate in frequency to meet the needs of the patients.

(a) The home health aide shall be assigned to a particular patient by a registered nurse. Written instructions for patient care shall be prepared by a registered nurse or therapist as appropriate. Duties may include the performance of simple procedures as an extension of therapy services, personal care, ambulation and exercises, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing appropriate records.

(b) The registered nurse, or appropriate professional staff member if other home health services are provided, shall make a supervisory visit to the patient's residence at least monthly, either when the aide is present to observe and assist or when the aide is absent (preferably alternating visits), to assess the aide's competence in providing care and determine whether goals are being met.

(c) There shall be continuing in-service programs on a regularly scheduled basis with on-the-job training during supervisor visits as issues are identified.

(12) Physical Therapy, Occupational Therapy and Speech Language Pathology Services. Physical therapy services, occupational therapy services, and speech language pathology services must be available and when provided, offered in a manner consistent with accepted standards of practice.

(13) Medical Supplies. Medical supplies and appliances, including drugs and biologicals, must be provided as needed for the palliation and management of the terminal illness or conditions directly attributable to the terminal diagnosis.

(a) Administration. All drugs and biologicals must be administered in accordance with accepted standards of practice and only by appropriately licensed employees of the hospice.

(b) The hospice must have a policy for the disposal of controlled drugs maintained in the patient's home or temporary place of residence when those drugs are no longer needed by the patient.

(c) Drugs and biologicals may be administered by the patient or his/her family member if the patient's attending physician has approved.

(14) Medical Records.

(a) A medical record containing past and current findings in accordance with accepted professional standards shall be maintained for every patient receiving hospice services. In addition to the plan of care, the record shall contain: appropriate identifying information; name of physician; all medications and treatments; and signed and dated clinical notes. Clinical notes shall be written the day on which service is rendered and incorporated no less often than weekly; copies of summary reports shall be sent to the physician; and a discharge summary shall be dated and signed within 7 days of discharge.

(b) A home care organization providing hospice services is authorized to receive and appropriately act on a written order for a plan of care for a patient concerning a home health service signed by a physician that is transmitted to the agency by electronically signed electronic mail. Such order that is transmitted by electronic mail shall be deemed to meet any requirement for written documentation imposed by this regulation.

(Rule 1200-8-27-.06, continued)

(c) All medical records, either written, electronic, graphic or otherwise acceptable form, must be retained in their original or legally reproduced form for a minimum period of at least ten (10) years after which such records may be destroyed. However, in cases of patients under mental disability or minority, their complete agency records shall be retained for the period of minority or known mental disability, plus one (1) year, or ten (10) years following the discharge of the patient, whichever is longer. Records destruction shall be accomplished by burning, shredding or other effective method in keeping with the confidential nature of the contents. The destruction of records must be made in the ordinary course of business, must be documented and in accordance with the agency's policies and procedures, and no record may be destroyed on an individual basis.

(d) Even if the agency discontinues operations, records shall be maintained as mandated by this Chapter and the Tennessee Medical Records Act (T.C.A. §§ 68-11-308). If a patient is transferred to another health care facility or agency, a copy of the record or an abstract shall accompany the patient when the agency is directly involved in the transfer.

(e) Medical records information shall be safeguarded against loss or unauthorized use. Written procedures govern use and removal of records and conditions for release of information. The patient's written consent shall be required for release of information when the release is not otherwise authorized by law.

(f) For purposes of this rule, the requirements for signature or countersignature by a physician or other person responsible for signing, countersigning or authenticating an entry may be satisfied by the electronic entry by such person of a unique code assigned exclusively to him or her, or by entry of other unique electronic or mechanical symbols, provided that such person has adopted same as his or her signature in accordance with established protocol or rules.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-3-511, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-260 and 68-11-304.* ***Administrative History:*** *Original rule filed April 17, 2000; effective July 1, 2000. Amendment filed September 13, 2002; effective November 27, 2002 Amendment filed February 23, 2007; effective May 9, 2007.*

1200-8-27-.07 RESERVED.

1200-8-27-.08 RESERVED.

1200-8-27-.09 RESERVED.

1200-8-27-.10 INFECTIOUS AND HAZARDOUS WASTE.

(1) Each agency must develop, maintain and implement written policies and procedures for the definition and handling of its infectious and hazardous waste. These policies and procedures must comply with the standards of this rule and all other applicable state and federal regulations.

(2) The following waste shall be considered to be infectious waste:

(a) Waste human blood and blood products such as serum, plasma, and other blood components;

(b) All discarded sharps (including but not limited to, hypodermic needles, syringes, pasteur pipettes, broken glass and scalpel blades) used in patient care; and

(c) Other waste determined to be infectious by the agency in its written policy.

(3) Waste must be packaged in a manner that will protect waste handlers and the public from possible injury and disease that may result from exposure to the waste. Such packaging must provide for

(Rule 1200-8-27-.10, continued)

containment of the waste from the point of generation up to the point of proper treatment or disposal. Packaging must be selected and utilized for the type of waste the package will contain, how the waste will be treated and disposed, and how it will be handled and transported prior to treatment and disposal.

(a) Contaminated sharps must be directly placed in leakproof, rigid and puncture-resistant containers which must then be tightly sealed.

(b) Infectious and hazardous waste must be secured in fastened plastic bags before placement in a garbage can with other household waste.

(c) Reusable containers for infectious waste must be thoroughly sanitized each time they are emptied, unless the surfaces of the containers have been completely protected from contamination by disposable liners or other devices removed with the waste.

(4) After packaging, waste must be handled, transported and stored by methods ensuring containment and preserving of the integrity of the packaging, including the use of secondary containment where necessary.

(5) Waste must be stored in a manner which preserves the integrity of the packaging, inhibits rapid microbial growth and putrefaction, and minimizes the potential of exposure or access by unknowing persons. Waste must be stored in a manner and location which affords protection from animals, precipitation, wind and direct sunlight, does not present a safety hazard, does not provide a breeding place or food source for insects or rodents and does not create a nuisance.

(6) In the event of spills, ruptured packaging, or other incidents where there is a loss of containment of waste, the agency must ensure that proper actions are immediately taken to:

(a) Isolate the area;

(b) Repackage all spilled waste and contaminated debris in accordance with the requirements of this rule; and

(c) Sanitize all contaminated equipment and surfaces appropriately.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, and 68-11-209.* ***Administrative History:*** *Original rule filed April 17, 2000; effective July 1, 2000.*

1200-8-27-.11 RECORDS AND REPORTS.

(1) A yearly statistical report, the "Joint Annual Report of Home Care Organizations", shall be submitted to the Department. The forms are mailed to each home care organization by the Department each year. The forms must be completed and returned to the Department as requested.

(2) Unusual events shall be reported by the facility to the Department of Health in a format designed by the Department within seven (7) business days of the date of the identification of the abuse of a patient or an unexpected occurrence or accident that results in death, life threatening or serious injury to a patient.

(a) The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient, not related to a natural course of the patient's illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to:

1. medication errors;

(Rule 1200-8-27-.11, continued)

2. aspiration in a non-intubated patient related to conscious/moderate sedation;

3. intravascular catheter related events including necrosis or infection requiring repair or intravascular catheter related pneumothorax;

4. volume overload leading to pulmonary edema;

5. blood transfusion reactions, use of wrong type of blood and/or delivery of blood to the wrong patient;

6. perioperative/periprocedural related complication(s) that occur within 48 hours of the operation or the procedure, including a procedure which results in any new central neurological deficit or any new peripheral neurological deficit with motor weakness;

7. burns of a second or third degree;

8. falls resulting in radiologically proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, and/or internal trauma, but does not include fractures resulting from pathological conditions;

9. procedure related incidents, regardless of setting and within thirty (30) days of the procedure and includes readmissions, which include:

   (i) procedure related injury requiring repair or removal of an organ;

   (ii) hemorrhage;

   (iii) displacement, migration or breakage of an implant, device, graft or drain;

   (iv) post operative wound infection following clean or clean/contaminated case;

   (v) any unexpected operation or reoperation related to the primary procedure;

   (vi) hysterectomy in a pregnant woman;

   (vii) ruptured uterus;

   (viii) circumcision;

   (ix) incorrect procedure or incorrect treatment that is invasive;

   (x) wrong patient/wrong site surgical procedure;

   (xi) unintentionally retained foreign body;

   (xii) loss of limb or organ, or impairment of limb if the impairment is present at discharge or for at least two (2) weeks after occurrence;

   (xiii) criminal acts;

   (xiv) suicide or attempted suicide;

   (xv) elopement from the facility;

(Rule 1200-8-27-.11, continued)

(xvi) infant abduction, or infant discharged to the wrong family;

(xvii) adult abduction;

(xviii) rape;

(xix) patient altercation;

(xx) patient abuse, patient neglect, or misappropriation of resident/patient funds;

(xxi) restraint related incidents; or

(xxii) poisoning occurring within the facility.

(b) Specific incidents that might result in a disruption of the delivery of health care services at the facility shall also be reported to the department, on the unusual event form, within seven (7) days after the facility learns of the incident. These specific incidents include the following:

1. strike by the staff at the facility;

2. external disaster impacting the facility;

3. disruption of any service vital to the continued safe operation of the facility or to the health and safety of its patients and personnel; and

4. fires at the facility which disrupt the provision of patient care services or cause harm to patients or staff, or which are reported by the facility to any entity, including but not limited to a fire department, charged with preventing fires.

(c) For health services provided in a "home" setting, only those unusual events actually witnessed or known by the person delivering health care services are required to be reported.

(d) Within forty (40) days of the identification of the event, the facility shall file with the department a corrective action report for the unusual event reported to the department. The department's approval of a Corrective Action Report will take into consideration whether the facility utilized an analysis in identifying the most basic or causal factor(s) that underlie variation in performance leading to the unusual event by (a) determining the proximate cause of the unusual event, (b) analyzing the systems and processes involved in the unusual event, (c) identifying possible common causes, (d) identifying potential improvements, and (e) identifying measures of effectiveness. The corrective action report shall either: (1) explain why a corrective action report is not necessary; or (2) detail the actions taken to correct any error identified that contributed to the unusual event or incident, the date the corrections were implemented, how the facility will prevent the error from recurring in the future and who will monitor the implementation of the corrective action plan.

(e) The department shall approve in writing, the corrective action report if the department is satisfied that the corrective action plan appropriately addresses errors that contributed to the unusual event and takes the necessary steps to prevent the recurrence of the errors. If the department fails to approve the corrective action report, then the department shall provide the facility with a list of actions that the department believes are necessary to address the errors. The facility shall be offered an informal meeting with the Commissioner or the Commissioner's representative to attempt to resolve any disagreement over the corrective action report. If the department and the facility fail to agree on an appropriate corrective action plan, then the final determination on the adequacy of the corrective action report shall be made by the Board after a contested case hearing.

(Rule 1200-8-27-.11, continued)

(f) The event report reviewed or obtained by the department shall be confidential and not subject to discovery, subpoena or legal compulsion for release to any person or entity, nor shall the report be admissible in any civil or administrative proceeding other than a disciplinary proceeding by the department or the appropriate regulatory board. The report is not discoverable or admissible in any civil or administrative action except that information in any such report may be transmitted to an appropriate regulatory agency having jurisdiction for disciplinary or license sanctions against the impacted facility. The department must reveal upon request its awareness that a specific event or incident has been reported.

(g) The department shall have access to facility records as allowed in Title 68, Chapter 11, Part 3. The department may copy any portion of a facility medical record relating to the reported event unless otherwise prohibited by rule or statute. This section does not change or affect the privilege and confidentiality provided by T.C.A. §63-6-219.

(h) The department, in developing the unusual event report form, shall establish an event occurrence code that categorizes events or specific incidents by the examples set forth above in (a) and (b). If an event or specific incident fails to come within these examples, it shall be classified as "other" with the facility explaining the facts related to the event or incident.

(i) This does not preclude the department from using information obtained under these rules in a disciplinary action commenced against a facility, or from taking a disciplinary action against a facility. Nor does this preclude the department from sharing such information with any appropriate governmental agency charged by federal or state law with regulatory oversight of the facility. However, all such information must at all times be maintained as confidential and not available to the public. Failure to report an unusual event, submit a corrective action report, or comply with a plan of correction as required herein may be grounds for disciplinary action pursuant to T.C.A. §68-11-207.

(j) The affected patient and/or the patient's family, as may be appropriate, shall also be notified of the event or incident by the facility.

(k) During the second quarter of each year, the Department shall provide the Board an aggregate report summarizing by type the number of unusual events and incidents reported by facilities to the Department for the preceding calendar year.

(l) The Department shall work with representatives of facilities subject to these rules, and other interested parties, to develop recommendations to improve the collection and assimilation of specific aggregate health care data that, if known, would track health care trends over time and identify system-wide problems for broader quality improvement. The goal of such recommendations should be to better coordinate the collection of such data, to analyze the data, to identify potential problems and to work with facilities to develop best practices to remedy identified problems. The Department shall prepare and issue a report regarding such recommendations.

(3) The agency shall retain legible copies of the following records and reports for thirty-six (36) months following their issuance. They shall be maintained in a single file, and shall be made available for inspection during normal business hours to any person who requests to view them:

(a) Department licensure surveys;

(b) Federal Health Care Financing Administration surveys and inspections, if any;

(c) Orders of the Commissioner or Board, if any; and

(Rule 1200-8-27-.11, continued)

(d) Comptroller of the Treasury's audit report and finding, if any.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-207, 68-11-209, 68-11-210, 68-11-211, and 68-11-213.* ***Administrative History:*** *Original rule filed April 17, 2000; effective July 1, 2000. Amendment filed April 11, 2003; effective June 25, 2003.*

1200-8-27-.12 PATIENT RIGHTS.

(1) Each patient has at least the following rights:

(a) To privacy in treatment and personal care;

(b) To be free from mental and physical abuse. Should this right be violated, the agency must notify the Department within five (5) business days. Suspected abuse of a patient shall be reported immediately to the Tennessee Department of Human Services, Adult Protective Services as required by T.C.A. §71-6-101 et seq.;

(c) To have appropriate assessment and management of pain;

(d) To be involved in the decision making of all aspects of their care;

(e) To refuse treatment. The patient must be informed of the consequences of that decision. A refusal and its reason must be reported to the physician and documented in the medical record;

(f) To refuse experimental treatment and drugs. The patient's or health care decision maker's written consent for participation in research must be obtained and retained in the medical record; and

(g) To have their records kept confidential and private. Written consent by the patient must be obtained prior to release of information except to persons authorized by law. If the patient lacks capacity, written consent is required from the patient's health care decision maker. The agency must have policies to govern access and duplication of the patient's record.

(2) Each patient has a right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment, including resuscitative services. This right of self-determination may be effectuated by an advance directive.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed April 17, 2000; effective July 1, 2000. Amendment filed June 18, 2002; effective September 1, 2002. Amendment filed December 2, 2005; effective February 15, 2006.*

1200-8-27-.13 POLICIES AND PROCEDURES FOR HEALTH CARE DECISION-MAKING.

(1) Pursuant to this Rule, each hospice agency shall maintain and establish policies and procedures governing the designation of a health care decision-maker for making health care decisions for a patient who is incompetent or who lacks capacity, including but not limited to allowing the withholding of CPR measures from individual patients. An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

(2) An adult or emancipated minor may execute an advance directive for health care. The advance directive may authorize an agent to make any health care decision the patient could have made while having capacity, or may limit the power of the agent, and may include individual instructions. The

(Rule 1200-8-27-.13, continued)

effect of an advance directive that makes no limitation on the agent's authority shall be to authorize the agent to make any health care decision the patient could have made while having capacity.

(3) The advance directive shall be in writing, signed by the patient, and shall either be notarized or witnessed by two (2) witnesses. Both witnesses shall be competent adults, and neither of them may be the agent. At least one (1) of the witnesses shall be a person who is not related to the patient by blood, marriage, or adoption and would not be entitled to any portion of the estate of the patient upon the death of the patient. The advance directive shall contain a clause that attests that the witnesses comply with the requirements of this paragraph.

(4) Unless otherwise specified in an advance directive, the authority of an agent becomes effective only upon a determination that the patient lacks capacity, and ceases to be effective upon a determination that the patient has recovered capacity.

(5) A facility shall use the mandatory advance directive form that meets the requirements of the Tennessee Health Care Decisions Act and has been developed and issued by the Board for Licensing Health Care Facilities.

(6) A determination that a patient lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent shall be made by the designated physician, who is authorized to consult with such other persons as he or she may deem appropriate.

(7) An agent shall make a health care decision in accordance with the patient's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the patient's best interest. In determining the patient's best interest, the agent shall consider the patient's personal values to the extent known.

(8) An advance directive may include the individual's nomination of a court-appointed guardian.

(9) A health care facility shall honor an advance directive that is executed outside of this state by a nonresident of this state at the time of execution if that advance directive is in compliance with the laws of Tennessee or the state of the patient's residence.

(10) No health care provider or institution shall require the execution or revocation of an advance directive as a condition for being insured for, or receiving, health care.

(11) Any living will, durable power of attorney for health care, or other instrument signed by the individual, complying with the terms of Tennessee Code Annotated, Title 32, Chapter 11, and a durable power of attorney for health care complying with the terms of Tennessee Code Annotated, Title 34, Chapter 6, Part 2, shall be given effect and interpreted in accord with those respective acts. Any advance directive that does not evidence an intent to be given effect under those acts but that complies with these regulations may be treated as an advance directive under these regulations.

(12) A patient having capacity may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider.

(13) A patient having capacity may revoke all or part of an advance directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

(14) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as an agent unless otherwise specified in the decree or in an advance directive.

(15) An advance directive that conflicts with an earlier advance directive revokes the earlier directive to the extent of the conflict.

(16) Surrogates.

(Rule 1200-8-27-.13, continued)

(a) An adult or emancipated minor may designate any individual to act as surrogate by personally informing the supervising health care provider. The designation may be oral or written.

(b) A surrogate may make a health care decision for a patient who is an adult or emancipated minor if and only if:

1. the patient has been determined by the designated physician to lack capacity, and

2. no agent or guardian has been appointed, or

3. the agent or guardian is not reasonably available.

(c) In the case of a patient who lacks capacity, the patient's surrogate shall be identified by the supervising health care provider and documented in the current clinical record of the facility at which the patient is receiving health care.

(d) The patient's surrogate shall be an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, who is reasonably available, and who is willing to serve.

(e) Consideration may be, but need not be, given in order of descending preference for service as a surrogate to:

1. the patient's spouse, unless legally separated;

2. the patient's adult child;

3. the patient's parent;

4. the patient's adult sibling;

5. any other adult relative of the patient; or

6. any other adult who satisfies the requirements of 1200-8-27-.13(16)(d).

(f) No person who is the subject of a protective order or other court order that directs that person to avoid contact with the patient shall be eligible to serve as the patient's surrogate.

(g) The following criteria shall be considered in the determination of the person best qualified to serve as the surrogate:

1. Whether the proposed surrogate reasonably appears to be better able to make decisions either in accordance with the known wishes of the patient or in accordance with the patient's best interests;

2. The proposed surrogate's regular contact with the patient prior to and during the incapacitating illness;

3. The proposed surrogate's demonstrated care and concern;

4. The proposed surrogate's availability to visit the patient during his or her illness; and

5. The proposed surrogate's availability to engage in face-to-face contact with health care providers for the purpose of fully participating in the decision-making process.

(Rule 1200-8-27-.13, continued)

(h) If the patient lacks capacity and none of the individuals eligible to act as a surrogate under 1200-8-27-.13(16)(c) thru 1200-8-27-.13(16)(g) is reasonably available, the designated physician may make health care decisions for the patient after the designated physician either:

1. Consults with and obtains the recommendations of a facility's ethics mechanism or standing committee in the facility that evaluates health care issues; or

2. Obtains concurrence from a second physician who is not directly involved in the patient's health care, does not serve in a capacity of decision-making, influence, or responsibility over the designated physician, and is not under the designated physician's decision-making, influence, or responsibility.

(i) In the event of a challenge, there shall be a rebuttable presumption that the selection of the surrogate was valid. Any person who challenges the selection shall have the burden of proving the invalidity of that selection.

(j) A surrogate shall make a health care decision in accordance with the patient's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.

(k) A surrogate who has not been designated by the patient may make all health care decisions for the patient that the patient could make on the patient's own behalf, except that artificial nutrition and hydration may be withheld or withdrawn for a patient upon a decision of the surrogate only when the designated physician and a second independent physician certify in the patient's current clinical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to regain capacity to make medical decisions.

(l) Except as provided in 1200-8-27-.13(16)(m):

1. Neither the treating health care provider nor an employee of the treating health care provider, nor an operator of a health care institution nor an employee of an operator of a health care institution may be designated as a surrogate; and

2. A health care provider or employee of a health care provider may not act as a surrogate if the health care provider becomes the patient's treating health care provider.

(m) An employee of the treating health care provider or an employee of an operator of a health care institution may be designated as a surrogate if:

1. the employee so designated is a relative of the patient by blood, marriage, or adoption; and

2. the other requirements of this section are satisfied.

(n) A health care provider may require an individual claiming the right to act as surrogate for a patient to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.

(17) Guardian.

(Rule 1200-8-27-.13, continued)

(a) A guardian shall comply with the patient's individual instructions and may not revoke the patient's advance directive absent a court order to the contrary.

(b) Absent a court order to the contrary, a health care decision of an agent takes precedence over that of a guardian.

(c) A health care provider may require an individual claiming the right to act as guardian for a patient to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.

(18) A designated physician who makes or is informed of a determination that a patient lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the authority of an agent, guardian, or surrogate, shall promptly record the determination in the patient's current clinical record and communicate the determination to the patient, if possible, and to any person then authorized to make health care decisions for the patient.

(19) Except as provided in 1200-8-27-.13(20) thru 1200-8-27-.13(22), a health care provider or institution providing care to a patient shall:

(a) comply with an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the patient; and

(b) comply with a health care decision for the patient made by a person then authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.

(20) A health care provider may decline to comply with an individual instruction or health care decision for reasons of conscience.

(21) A health care institution may decline to comply with an individual instruction or health care decision if the instruction or decision is:

(a) contrary to a policy of the institution which is based on reasons of conscience, and

(b) the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.

(22) A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medically inappropriate health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.

(23) A health care provider or institution that declines to comply with an individual instruction or health care decision pursuant to 1200-8-27-.13(20) thru 1200-8-27-.13(22) shall:

(a) promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient;

(b) provide continuing care to the patient until a transfer can be effected or until the determination has been made that transfer cannot be effected;

(c) unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision; and

(Rule 1200-8-27-.13, continued)

(d) if a transfer cannot be effected, the health care provider or institution shall not be compelled to comply.

(24) Unless otherwise specified in an advance directive, a person then authorized to make health care decisions for a patient has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information.

(25) A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for:

(a) complying with a health care decision of a person apparently having authority to make a health care decision for a patient, including a decision to withhold or withdraw health care;

(b) declining to comply with a health care decision of a person based on a belief that the person then lacked authority; or

(c) complying with an advance directive and assuming that the directive was valid when made and had not been revoked or terminated.

(26) An individual acting as an agent or surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for health care decisions made in good faith.

(27) A person identifying a surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for such identification made in good faith.

(28) A copy of a written advance directive, revocation of an advance directive, or designation or disqualification of a surrogate has the same effect as the original.

(29) The withholding or withdrawal of medical care from a patient in accordance with the provisions of the Tennessee Health Care Decisions Act shall not, for any purpose, constitute a suicide, euthanasia, homicide, mercy killing, or assisted suicide.

(30) Universal Do Not Resuscitate Order (DNR).

(a) The Physicians Order for Scope of Treatment (POST) form, a mandatory form meeting the provisions of the Health Care Decision Act and approved by the Board for Licensing Health Care Facilities, shall be used as the Universal Do Not Resuscitate Order by all facilities. A universal do not resuscitate order (DNR) may be used by a physician for his/her patient with whom he/she has a physician/patient relationship, but only:

1. with the consent of the patient; or

2. if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act; or

3. if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order and the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act is not reasonably available, the physician determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.

(Rule 1200-8-27-.13, continued)

(b) If the patient is an adult who is capable of making an informed decision, the patient's expression of the desire to be resuscitated in the event of cardiac or respiratory arrest shall revoke a universal do not resuscitate order. If the patient is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the patient be resuscitated by the person authorized to consent on the patient's behalf shall revoke a universal do not resuscitate order.

(c) Universal do not resuscitate orders shall remain valid and in effect until revoked. Qualified emergency medical services personnel, and licensed health care practitioners in any facility, program or organization operated or licensed by the board for licensing health care facilities or by the department of mental health and developmental disabilities or operated, licensed, or owned by another state agency are authorized to follow universal do not resuscitate orders.

(d) Nothing in these rules shall authorize the withholding of other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or to alleviate pain.

(e) If a person with a universal do not resuscitate order is transferred from one health care facility to another health care facility, the health care facility initiating the transfer shall communicate the existence of the universal do not resuscitate order to the receiving facility prior to the transfer. The transferring facility shall assure that a copy of the universal do not resuscitate order accompanies the patient in transport to the receiving health care facility. Upon admission, the receiving facility shall make the universal do not resuscitate order a part of the patient's record.

(f) This section shall not prevent, prohibit, or limit a physician from issuing a written order, other than a universal do not resuscitate order, not to resuscitate a patient in the event of cardiac or respiratory arrest in accordance with accepted medical practices.

(g) Valid do not resuscitate orders or emergency medical services do not resuscitate orders issued before July 1, 2004, pursuant to the then-current law, shall remain valid and shall be given effect as provided.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-224, 68-11-1801 through 68-11-1815.* ***Administrative History:*** *Original rule filed April 17, 2000; effective July 1, 2000. Amendment filed April 28, 2003; effective July 12, 2003. Repeal and new rule filed December 2, 2005; effective February 15, 2006. Amendment filed February 7, 2007; effective April 23, 2007.*

1200-8-27-.14 DISASTER PREPAREDNESS.

(1) All agencies shall establish and maintain communications with the local office of the Tennessee Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The agency shall cooperate, to the extent possible, in area disaster drills and local emergency situations.

(2) A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, and 68-11-209.* ***Administrative History:*** *Original rule filed April 17, 2000; effective July 1, 2000.*

1200-8-27-.15 APPENDIX I

(1) Physician Orders for Scope of Treatment (POST) Form

(Rule 1200-8-27-.15, continued)

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders for Scope of Treatment (POST)	Patient's Last Name
This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.	First Name/Middle Initial
	Date of Birth

Section A — Check One Box Only

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing.

☐ Resuscitate (CPR) ☐ Do Not Attempt Resuscitate (DNR/no CPR)

When not in cardiopulmonary arrest, follow orders in B, C, and D.

Section B — Check One Box Only

MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.

☐ Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.

☐ Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.

☐ Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.

Other Instructions:_____

Section C — Check One Box Only

ANTIBIOTICS – Treatment for new medical conditions:

☐ No Antibiotics

☐ Antibiotics

Other Instructions:_____

Section D — Check One Box Only in Each Column

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION. Oral fluids and nutrition must be offered if medically feasible.

☐ No IV fluids (provide other measures to assure comfort)	☐ No feeding tube
☐ IV fluids for a defined trial period	☐ Feeding tube for a defined trial period
☐ IV fluids long-term if indicated	☐ Feeding tube long-term

Other Instructions:_____

Section E — Must be Completed

Discussed with:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐
Other:_____(Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical indications
☐ (Other)_____

Physician Name (Print)	Physician Phone Number	Office Use Only
Physician Signature (Mandatory)	Date	

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

(Rule 1200-8-27-.15, continued)

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY			
Signature of Patient, Parent of Minor, or Guardian/Health Care Representative			
Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences. (If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)			
Signature	Name (print)	Relationship (write "self" if patient)	
Contact Information			
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

POST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

(1) The patient is transferred from one care setting or care level to another, or
(2) There is a substantial change in the patient's health status, or
(3) The patient's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

(2) Advance Care Plan Form

(Rule 1200-8-27-.15, continued)

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name:_____ Phone #: _____ Relation: _____

Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name:_____ Phone #: _____ Relation: _____

Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):

☐ Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

☐ Permanent Confusion: I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

☐ Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.

☐ End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.

☐ Yes ☐ No	CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	Life Support/Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
☐ Yes ☐ No	Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	Tube feeding/IV fluids: Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions, such as burial arrangements, hospice care, etc.:_____

(Rule 1200-8-27-.15, continued)

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: _____ DATE:_____
(Patient)

Witnesses:

1, I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form. _____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form. _____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF_____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005
Acknowledgement to Project GRACE for inspiring the development of this form.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.* ***Administrative History:*** *Original rule filed February 16, 2007; effective May 2, 2007.*